



What is a Remittance Advice (RA)?

The RA provides detailed payment information relative to the health care claim(s) and, if applicable, why the total original charges have not been paid in full. The RA information is provided as documentation for payment.

The amounts reported on the RA **must** balance at three different levels:

1. Service line
2. Claim
3. Transaction

The RA shows what has been paid, denied, adjusted, or denied adjusted on a claim, in order by billing number. Members are listed in alphabetical order within each of these groups (paid, denied, adjusted, denied adjusted).

The RA consists of three sections:

Section 1: Summary Page

- Total Paid
- Denied
- Adjusted (by provider number)

Section 2: Detail Page

- All TCN's detailed by line
- Listed in alphabetical order by member by group (paid, denied, adjusted, denied adjusted)

Section 3: Legend Page

- All remark and adjustment codes and descriptions listed on the RA

Due to batch processing, the RA's cannot start with page 1 for each provider. The pages are numbered as printed and continue until all RA's are printed. This is to assure that no RA pages are missing due to printing errors.

Section 1: Summary Page

The summary page will list all billing numbers paid, denied, adjusted, or denied adjusted on this RA.

1. Provider name and address
2. RA number: The number given to this RA. This will appear on the 835.
3. Vendor: Provider identifier assigned by AdvantageME
4. Check/Trace#: Check number for this RA. This number will not match the "Paymode" check number. ("Paymode" number starts with the 4-digit year followed by the Paymode check number).
Please Note: \$0 balance RA's have no Check/Trace #.
5. Check Date: Date check is issued.
6. Check Amount: Check amount for this RA. The Check amount listed on the RA should always match the actual check amount received (paper or EFT)
7. Payment Method: How the payment was made.
 - Electronic Fund Transfer (EFT)
 - Paper check
 - Non-Payment Data (for RA with no payment)

8. Prepared Date: Date the RA was printed. If an RA is re-printed, it will display the re-print date.
9. RA Date: Date the RA was generated for the first time.
10. Claims Summary (**Left side RA summary**)
11. Provider adjustments (**Right side of RA summary**).
12. The Oracle Financial Invoice Number (**OFIN**) is the number in the Oracle Financial System that tracks the receivable/payable. Letters that appear before the numbers help to identify what the fee covers. Some examples are:
 - ADJDEL###:** Drugs for the Elderly Pharmacy Incentive Payment
 - ADJR###:** RX Pharmacy Incentive Payment
 - ABMCPEO:** Maine Ambulance Association Certified Public Expenditure (happens twice/year)
 - AVS###:** A void in the system
 - CM#####:** Credit Memo related to adjustment to claims
 - CAN###:** Reimbursement for Certified Nurses Aide
 - CSH###:** Cost Settlement
 - PIPFY07150-9-wk:** Provider Incentive Payment fiscal year 2007, week 9
13. Source: To distinguish which type of recoupment or payment

Adjustment Source (Paper RA)	OFIN HIPAA Code (835)
A-State Initiated-Adj Unit	CS-Adjustment
C-TPL Medicare Adj	TL-Third Party Liability
D-State Initiated-Audit	IS-Interim Settlement
F-Management Fee <ul style="list-style-type: none"> • Per member/per month • Payment run the 3rd week of every month • Member Roster mailed a few days after the RA date 	BN-Bonus
I-CCI Initiated	CS-Adjustment
IP-Incentive Premium Payment <ul style="list-style-type: none"> • Paid to Managed Care Primary Care Provider Sites • Paid twice/year (June/December or January/July) • Site gets formal letter, score breakdown of quality/prevention measures used to calculate incentive payment 	IP-Incentive Premium Payment
L-TPL Insurance Adj	TL-Third Party Liability
M-State Initiated-MBCHP	CS-Adjustment
P-Provider Initiated-Paper/Elec	CS-Adjustment
R-Retroactive Rate Change	RA-Retro-Active Adjustment
S-State Initiated-SURS	WO-Overpayment Recovery
T-State Initiated-TPL	TL-Third Party Liability
X-System Initiated Adjustments	CS-Adjustment

14. Adjustment Type
15. Previous Balance Amount: Any receivable balances from previous RA's
16. Adjustment Amount: Adjustment amount on this RA
17. Remaining Balance Amount: Remaining Balance of receivables after this RA

Interim payments show on the "Providers Adjustments" side of the RA. The Source column identifies the adjustment as "A-State Initiated-Adj Unit" or "None." The "Adjustment Type" column will note "Adjustment." "Take-backs" appear in the Adjustment Amount column. You may see multiple adjustment amounts for a single provider number. These represent different time-periods for interim payments.

Section 2: Detail Page

1. Categories

- **Paid or Paid-MBCHP: All paid claims**

Lines must equal. If the Total Billed, Allowed Amount, and Total Paid amounts are not all the same, the codes and totals in the Adjustment column must be used to balance the amounts. Paid-MBCHP lists Maine Breast and Cervical Health Program paid claims separately.

- **Denied or Denied-MBCHP: All denied claims**

All denied claims will be listed with remark and/or adjustment codes. The definition of each remark/adjustment code will be listed on the Legend page of the RA. Determine what corrections may be required and re-bill the claims when appropriate. Any questions regarding specific denials, please call Billing & Information at 1-800-321-5557 Option 8. Denied-MBCHP lists Maine Breast and Cervical Health Program denied claims separately.

- **Adjust: All adjusted claims**

Adjustments and Voids will appear on the Category Adjustment.

Claims will show in order by billing number, member alpha order within each group.

The credit claim will appear first, the reprocessed claim will appear directly under the credit claim. Voids will also appear.

- **Adj-Deny: Claims that were submitted for adjustment that have been denied**

All denied Adjustments and Voids will be listed with remark and/or adjustment codes. The definition of each remark/adjustment code will be listed on the Legend Page of the RA. Determine what corrections may be required and re-bill the claims when appropriate. Any questions regarding specific denials, please call Billing & Information at 1-800-321-5557 Option 8.

2. Member MaineCare ID, Medical record number, Patient account number: This is the member name, MaineCare ID and patient account number, if applicable
3. TCN/Claim Type: The Transaction Control Number (TCN) document number of the claim and the type of claim (i.e., Professional, Nursing Facility, Transportation, etc) billed on the claim line.
4. Line number: The line of the particular claim - Each line billed has a line number
5. Rendering Provider/RX number: Servicing provider for line billed
6. Service Date(s): Dates of Service billed on claim line in 8 digit format (MMDDYYYY)
7. Rev/Proc/Mod/NDC: Revenue/Procedure code, modifier or NDC code billed on claim line
8. Total Units/D/S: Total units/days/service billed on claim line - Must bill with at least one unit
9. Billed Amount/Cost Used: Billed amount on claim line
10. Allowed Amount / Fee: Allowed amount for procedure/revenue code
11. Paid Amount: Amount paid
12. MECMS Adjustment Source: Displayed on the Category Adjustment page of the RA
13. Offset: If the claim is being offset, a Y (yes) or N (no) will be displayed on the Category: The paid, denied and denied adjustment categories will be blank.

- Offset = "Y" indicates that money is owed from the provider and scheduled to be recovered in this RA. If there are not enough payments to cover the offset, a receivable is created to recover from the next RA cycle.

- Offset = "N" indicates that recovery is not scheduled to occur at this time.

Please Note: Recoupments have appeal rights. The balance will show, but will not be collected automatically until all appeal rights have been exhausted.

14. Remark Codes: Remark codes for each line, if applicable, will be listed here. The **definition** of remark codes will appear on the Legend Page of the RA.
15. Adjustments: Any adjustments on claims must be identified and will appear in this column. Adjustments can be a plus or a minus. This is to balance the claim. Third Party Liability and Member Responsibility amounts are included in the Adjustments.

The following also appear on the detail pages:

Document Total

- Totals in each column for each TCN

Category Totals (when applicable)

- The total of each column by Category (paid, denied, adjusted, adj-denied)

Billing Provider Total (when applicable)

- The total of each column by Billing provider number

Section 3: Legend Page

Description of any remark or adjustment code listed in the current RA

Hospital Tips

A2=Payment for In – State Hospitals

For Hospitals who receive PIP payments, the payment column is not used and shows Paid at \$0. In most cases, the allowed amount equals the payment. A2 is used to reflect this payment. In other cases A2 does not equal payment. When the third party liability column is greater than the allowed amount column, and when MaineCare reimburses hospitals for services that are not included in their PIP payments (i.e. Maine Breast and Cervical Health Program).

23=Third Party Liability (TPL)

When the TPL amount is greater than the allowed amount, no additional payment from MaineCare will be made. Ignore codes and amounts in the Adjustment column. The balance after the third party payment is your contractual obligation.

42= Contractual Adjustments

It will not always be necessary to post the 42 contractual adjustments. The only time a contractual adjustment is necessary is when there is a difference between the charged amount and the allowed amount. If the original claim was processed with a 42 contractual adjustment, post the void/adjustment claim using the 42 contractual adjustment codes. If the original claim did not reflect a contractual adjustment code 42, there is no need to post the 42.

142=Spendedowns:

- For a short period of time 142 was being used to reflect hospital PIP payments in place of A2. This affected remittance advices from 1/6/06 through 7/1/06. On 7/1/06 MeCMS upgrade reverted back to utilizing A2 to reflect these payments.
- **Paper RA's:**
Spendedown claims for hospitals have never processed correctly in MeCMS. MeCMS applies the total spenddown amount to each line. If you have previously submitted a spenddown claim, post the allowed amount as the paid amount. Ignore other codes that appear in the adjustment reason column. An adjustment claim will need to be submitted once the spenddown issue has been fixed. The expected date spenddown will be fixed is 03/05/08.
- **Electronic RA/835**
Adjustment codes that start with Contractual Obligation (CO) are usually programmed to post a credit transaction from the 835 to your accounting systems. If providers choose to continue using the 835 for posting their MaineCare remittances they will need to make adjustments to their program to ensure that the "142" is posting a Claim Adjustment Segment (CAS) group code Patient Responsibility (PR) and not CO.